VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

October 29, 2013

Ms. Margaret Rocque, Administrator
Heaton Woods
10 Heaton Street
Montpelier, VT 05602

Provider #: 0297

Dear Ms. Rocque:

Enclosed is a copy of your acceptable plans of correction for the unannounced onsite re-licensing survey and investigation of one entity report and two complaints conducted from September 24, 2013 and completed on **September 25, 2013.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

PRINTED: 10/09/2013
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0297	A. BUILDING: _____ B. WING _____	C 09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEATON WOODS	10 HEATON STREET MONTPELIER, VT 05602

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R100	Initial Comments: An unannounced onsite re-licensing survey and investigation of one entity report and two complaints were completed by the Division of Licensing and Protection from 9/24/13 through 9/25/13. Based on information gathered, regulatory violations were cited as follows.	R100	Please see attached Plans of Correction.	
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the Registered Nurse (RN) failed to oversee the development of a care plan for each resident which describes the care and services necessary to assist the resident to maintain independence and well-being for 4 of 7 residents in the sample (Residents #1, 5, 6, 7). Findings include: 1. During record review on 9/24-25/13, Resident #1 had documented falls on 8/9, 8/23, 9/6, and 9/23/13. The written plan of care for Resident #1 did not reflect or address falls risk or measures to prevent falls. During record review for Resident #7, it was evident that the resident had falls on 5/3, 6/21, 6/28, 7/1, 7/12, and during the overnight period 7/19-20/13. The facility's written plan of care did not address fall risk or fall prevention measures. During an interview on	R145		

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R145	Continued From page 1 9/25/13 at 7:15 AM, the Administrator confirmed that the written plans of care for Resident #1 and Resident #7 did not address risk for falls or strategies for prevention of falls. 2. During record reviews on 9/24-25/13, it was found that the RN had not signified development or oversight of the written plan of care for 4 of 7 residents in the sample (Residents #1, 5, 6, 7). The written plans of care had been developed and signed by a Licensed Practical Nurse (LPN). During an interview on 9/24/13 at 2:45 PM, the Director of Nursing (DNS) confirmed that the written care plans for Residents #1, 5, 6, and 7 were signed by the LPN. On 9/25/13 at 7:15 AM, the Administrator further confirmed that the LPN had developed and signed the written care plans for Residents #1, 5, 6, and 7. Per the December 2012 Vermont State Board of Nursing: The Role of the Licensed Practical Nurse in Patient Assessment and Triage: Position Statement, "LPNs may not independently assess the health status of an individual or group or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN, APRN, or other authorized health care practitioner."	R145		
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:	R167		

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R167	Continued From page 2 (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the Registered Nurse (RN) failed to assure that unlicensed staff administering as needed (PRN) psychoactive medications had a written plan which describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; and assures that staff document the reason for and specific results of the medication use for 4 of 7 residents in the sample (Residents 2, 4, 6, and 7). Findings include: During record review on 9/24-25/13, it was revealed that Residents # 2, 4, 6 and 7 have physician orders for as needed (PRN) psychoactive medications, such as lorazepam to address anxiety, Seroquel for agitation, or Haldol for severe agitation. Upon further investigation, there was no evidence that the RN had provided a system of behavior monitoring or specific guidance as to which circumstances would warrant the use of the as needed medications, or a manner in which the staff could record non-pharmacological interventions attempted	R167		

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R167	Continued From page 3 prior to resorting to the medication use. Additionally, per review of the Medication Administration Records (MAR), staff had on many occasions failed to document the specific results of the PRN psychoactive medication use. For Resident #2, staff administered lorazepam 0.5 mg by mouth for anxiety or restlessness on 9/20/13 and 9/24/13 without documenting the result. For Resident #4, staff administered lorazepam 0.5 mg by mouth on 9/1, 9/3, 9/5, 9/9, 9/15, 9/16, 9/18, 9/19, and 9/23/13 without documenting the result. For Resident #6, staff administered Seroquel 12.5 mg by mouth for agitation on 9/13/13 without documenting the result. For Resident #7, staff administered lorazepam 0.25 mg by mouth on 7/8, 7/14, 7/16, 7/17, 7/18, and 7/19/13 for agitation, without documenting the result. Additionally, staff administered Haldol 0.5 mg for anxiety/agitation without documenting results on 7/9, 7/11, 7/13 (10:45 AM and 5 PM), 7/16, 7/18, 7/19, 7/20/13 (1 mg at 10 AM). During an interview on the morning of 9/24/13, the Director of Nursing (DNS) confirmed that behaviors are monitored "by exception". During an interview on 9/25/13 at 7:15 AM, the Administrator further confirmed that the facility lacks a behavior monitoring system and that the MAR follow up documentation of PRN medication use was incomplete for Residents # 2, 4, 6, and 7.	R167		
R178 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services	R178		

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R178	Continued From page 4 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the home failed to assure the necessary oversight to maintain a safe environment for 1 of 7 residents in the sample (Resident #7) who had 2 falls in one overnight period after having been administered multiple doses of psychoactive medication. Findings include: Per record review, Resident #7 had a history of falls on 5/3, 6/21, 6/28, 7/1, 7/12, 7/19, and 7/20/13. The written plan of care for Resident #7 was developed and signed by a Licensed Practical Nurse (LPN) and did not address falls, as confirmed by the Administrator on 9/25/13 at 7:15 AM. On 6/25/13 Resident #7 was enrolled in hospice care and began receiving additional nurse and aid care from the hospice agency. The hospice agency had a separate written plan of care for their services, while the resident remained under the general care and services of Heaton Woods. Per review of the Medication Administration Record (MAR), Resident #7 was administered Haldol (an anti-psychotic medication) 1 mg at 2:30 PM for wandering and confusion, then lorazepam (an anti anxiety medication) 0.25 mg at 2:30 PM, and lorazepam 1 mg at 6:30 PM on 7/19/13 related to continued agitation. In an addendum nurse note dated 7/19/13, Resident #7 is noted to have fallen backward at approximately 12:00 AM, witnessed by a staff member in the	R178		

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R178	Continued From page 5 bedroom, resulting in 2 skin tears. Resident #7 had continued to be "agitated" during the night/early morning of 7/19-20/13 and staff had been instructed by the hospice Registered Nurse (RN) to administer 2 mg doses of Haldol at 1:30 AM and 2:30 AM, and 1 mg Haldol at 10:00 AM. At 10:40 AM, Resident #7 was found on the floor of his/her room, resulting in a skin tear.	R178		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the licensee failed to assure that no one employed on staff had been convicted of crimes inimical to the	R181		

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R181	Continued From page 6 public welfare for 1 of 5 individuals in the employee background check sample. Findings include: During review of employee background check records on 9/24/13, it was evident on the Vermont Criminal Information Center's (VCIC) record that one employee had been convicted of misdemeanor/disorderly conduct on 9/24/97, and was sentenced to incarceration for 60 days, suspended with probation concurrent. Additionally, the employee was convicted of misdemeanor/assault-domestic on 9/24/97, and was sentenced to incarceration for 12 months, suspended with probation. No waiver for employment of this person had been requested or obtained from the Division of Licensing and Protection. During an interview on 9/24/13 at 3:00 PM, the Administrator confirmed that the VCIC record had not come to his/her attention, and that no waiver for employment had been requested or obtained.	R181		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the home failed to assure that every resident was treated with respect, consideration, and full recognition of the resident's dignity and individuality when a dietary staff used profanity	R213		

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R213	Continued From page 7 and made comments which specifically degraded the individual in regard to his/her medical condition (1 of 7 residents in the sample, Resident #1). Findings include: Per review of the facility's internal investigation documents, the Kitchen Director wrote on 5/24/13 that on Sunday, May 19, employee A called to give him/her a "heads up" that employee B had crossed the line with Resident #1 on Saturday afternoon. Employee B was said to have become increasingly agitated by the requests of Resident #1 and told him/her to "cut the crap". Employee B reportedly went on to say to Resident #1 that s/he had a brother with the same mental illness, far worse, and that Resident #1 may be faking his/her mental illness for personal gain. At one point, Employee B told Resident #1 s/he was a "F..in' pain in the ass". During an interview on 9/24/13 at 1:00 PM, the Kitchen Director confirmed that Employee B had at times shared his/her resentment toward the brother who displayed similar characteristics as Resident #1 and shared the same diagnosis. The Kitchen Director confirmed the events of the written statement during the interview. Regarding this incident, in a statement dated 6/14/13, Employee A stated that s/he had witnessed Employee B and Resident #1 at about 10:45 AM in conversation. Employee B first said, "Do you know what your problem is?" At this time, Employee A witnessed Resident #1 walk away from Employee B toward the dining room, and Employee B followed him/her to the dining room and was heard saying the name of Resident #1, and "you are a f....ing pain in the ass to everyone here". Later in conversation with Employee A, Employee B referred to Resident #1 as a burden like [his/her] brother. In a statement dated	R213		

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R213	Continued From page 8 6/13/13, a dining room worker denied witnessing the exchange between Employee B and Resident #1; however, s/he noted that toward suppertime Resident #1 seemed upset, ate quickly, then left. During an interview at 3:00 PM on 9/24/13, the Administrator confirmed having dismissed Employee B based on the internal investigation into the reported treatment of Resident #1.	R213		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the home failed to assure that every resident (1 of 7 in the sample, Resident #1) was free from mental and verbal abuse, when a dietary staff used profanity and made comments which specifically degraded the individual in regard to his/her medical condition. Findings include: Per review of the facility's internal investigation documents, the Kitchen Director wrote on 5/24/13 that on Sunday, May 19, employee A called to give him/her a "heads up" that employee B had crossed the line with Resident #1 on Saturday afternoon. Employee B was said to have become increasingly agitated by the requests of Resident #1 and told him/her to "cut the crap". Employee B reportedly went on to say to Resident #1 that s/he had a brother with the same mental illness, far worse, and that Resident #1 may be faking	R224		

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R224	Continued From page 9 his/her mental illness for personal gain. At one point, Employee B told Resident #1 s/he was a "F....in' pain in the ass". During an interview on 9/24/13 at 1:00 PM, the Kitchen Director confirmed that Employee B had at times shared his/her resentment toward the brother who displayed similar characteristics as Resident #1 and shared the same diagnosis. The Kitchen Director confirmed the events of the written statement during the interview. Regarding this incident, in a statement dated 6/14/13, Employee A stated that s/he had witnessed Employee B and Resident #1 at about 10:45 AM in conversation. Employee B first said, "Do you know what your problem is?" At this time, Employee A witnessed Resident #1 walk away from Employee B toward the dining room, and Employee B followed him/her to the dining room and was heard saying the name of Resident #1, and "you are a f....ing pain in the ass to everyone here". Later in conversation with Employee A, Employee B referred to Resident #1 as a burden like [his/her] brother. In a statement dated 6/13/13, a dining room worker denied witnessing the exchange between Employee B and Resident #1; however, s/he noted that toward suppertime Resident #1 seemed upset, ate quickly, then left. During an interview at 3:00 PM on 9/24/13, the Administrator confirmed having dismissed Employee B based on the internal investigation into the reported treatment of Resident #1. It was additionally confirmed during the interview that Employee B was working without a waiver for employment, having shown conviction of two misdemeanors for disorderly conduct and assault-domestic on the employee pre-hire criminal background check.	R224		

HEATON WOODS – PLAN OF CORRECTION FOR SURVEY OF 9/25/13

R145 – The care plans for residents #1, 5 and 6 will be revised to address each resident's identified needs (care and services). Resident #7 is deceased. Date of completion: 10/29/13

All residents have the potential to be affected by the deficient practice. The RN will oversee the development of a written plan of care for each resident of the home and will assure that each care plan is complete and addresses the current needs of each resident.

The RN will conduct of review of all care plans to assure that care plans are accurate and current. Date of completion: 11/25/13

The RN will review a sample of 5 resident care plans weekly for 2 months to monitor for continued accuracy in addressing each resident's current needs. Date: 1/25/14

The Administrator will monitor the plan for compliance. Date: 11/25/13 and ongoing.

R167 – The home will utilize a newly implemented PRN Psychotropic Medication Plan for any resident who has physician orders for administration of a PRN psychotropic medication. All nursing staff who administer PRN psychotropic medications, including non-licensed care-givers and licensed nurses, will be trained in the use of the Plan. The plan will address the specific behaviors the medication is intended to address; specifies the circumstances that indicate when to use the medication; and educates staff about desired outcome and possible undesired side effects to monitor the resident for. Staff must document the time of, reason for and specific medication use and effect. Date of completion: 11/19/13

The new Plan will be developed for Residents #4 and #6 (Residents #2 and #7 are deceased). Date of completion: 10/31/13

All resident's with physician orders for PRN psychoactive medications will have the required Plan completed and implemented. Date of completion: 11/19/13

The RN will educate staff, develop each applicable resident's plan and oversee this plan to assure that compliance is attained and maintained. Date of completion: 11/19/13 and ongoing.

The Administrator will the monitor compliance with the corrective plan. Date: 11/19/13 and ongoing.

R178 – All nursing staff will be in-serviced on how to provide appropriate care to assure the safety and well-being of resident's demonstrating behaviors which pose a risk of significant injury to themselves or others. A protocol will be implemented to assure that staff on duty notify the designated responsible person for further instructions when a resident is exhibiting unsafe behavior, including a change in physical/medical status or repeated falls in a short period of time. The responsible person will direct staff in how to manage the resident's care and provide for additional staff resources as necessary for the situation. (Resident #7 is now deceased).

The Administrator will assure corrective action is implemented and monitor for ongoing compliance. Date of completion: 11/19/13

R181 – The home shall comply with it's policies to assure that all employed staff will have all required background checks completed, including reference checks, VT Abuse Registry checks and Vermont

R145, R167, R178, R181, R213 + R224 POC's accepted 10/23/13 JHosmerRN/PMC

criminal records check. The employee cited had been terminated from employment at the time of the survey. All current employee files will be reviewed to assure compliance with background checks and all new prospective employees will have the required background checks completed and satisfied prior to start of employment at the home.

The Administrator will assure that the plan is implemented and will review all new employee background checks prior to employment to assure ongoing compliance. Date of completion: 11/12/13

R213 – The home terminated the employee involved in this violation of Resident #1's rights after becoming aware of the event. Staff failed to take appropriate action by immediately notifying the Dietary supervisor and/or Administrator of this violation of a resident's right to be treated with respect and dignity. A mandatory in-service to re-educate staff on Resident Rights will be completed for all staff. Policies will be reviewed and revised to assure that staff have an immediate plan of action for any incidents involving resident mistreatment by abuse or any violation of the residents' rights. All managers will be educated on how to respond to reports of possible resident mistreatment by abuse or a violation of resident rights. Employees observed to be engaged in mistreatment or abusive actions towards any residents will be immediately reported to the manager on duty or administrator-designee. Such employees may be suspended pending the outcome of the investigation.

The Administrator will monitor for compliance and assure the implementation of the corrective action.

Date of completion: 11/19/13

R224 – The home will not tolerate any actions by any staff which are considered to be abusive in any way or a violation of the resident's rights. The home will have a mandatory in-service for all staff to review resident abuse policies/procedures to assure that all residents are free from abuse. Policies will be reviewed and revised, as necessary, to assure that staff have an immediate plan of action for any incidents involving alleged/actual resident abuse. All managers will be educated on how to respond to reports of resident mistreatment or abuse. All reports of resident abuse will be immediately reported to the manager on duty and/or the administrator-designee, who will direct staff on the appropriate action to take, and assure that the State Agency, APS is notified timely.